BlueCross BlueShield
Federal Employee Program

SPRYCEL
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Sprycel / Phyrago (dasatinib)

NOTE: Form must be completed in its **entirety** for processing

Please select medication/strength and provide quantity:

❑ **Sprycel**	❑ **20 mg qty _____ per 90 days**	❑ **80 mg qty _____ per 90 days**
	❑ **50 mg qty _____ per 90 days**	❑ **100 mg qty _____ per 90 days**
	❑ **70 mg qty _____ per 90 days**	❑ **140 mg qty _____ per 90 days**
❑ **Phyrago**	❑ **20 mg qty _____ per 90 days**	❑ **80 mg qty _____ per 90 days**
	❑ **50 mg qty _____ per 90 days**	❑ **100 mg qty _____ per 90 days**
	❑ **70 mg qty _____ per 90 days**	❑ **140 mg qty _____ per 90 days**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on Sprycel continuously for the last **6 months** excluding samples? ***Please select answer below:***
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
     - a. **BRAND Sprycel/Phyrago Request (Standard Option Patient)**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to generic Sprycel/Phyrago (dasatinib)? ❑Yes ❑No
     - b. What is the patient's diagnosis?
       - ❑ Gastrointestinal stromal tumor (GIST)
         - i. Does the patient's tumor have the PDGFRA D842V mutation? ❑Yes ❑No
         - ii. Has the patient had prior therapy with imatinib (Gleevec), sunitinib (Sutent) or regorafenib (Stivarga)? ❑Yes ❑No
       - ❑ Philadelphia chromosome positive chronic myeloid leukemia (Ph + CML)
         - i. Has the presence of the Ph chromosome or BCR-ABL gene been confirmed by molecular testing? ❑Yes ❑No
         - ii. Has the patient had prior therapy with a TKI? ❑Yes* ❑No
           - ***If YES***, please answer the following questions:
             - 1) Has the member experienced toxicity or intolerance to prior therapy with a TKI? ❑Yes ❑No
             - 2) Has the member experienced resistance to prior therapy with a TKI? ❑Yes ❑No
             - 3) Has the patient been tested for T315I mutation? ❑Yes* ❑No
               - ***If YES***, what was the test result? ❑Negative ❑Positive
       - ❑ Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)
         - i. Has the presence of the Ph chromosome or BCR-ABL gene been confirmed by molecular testing? ❑Yes ❑No
         - ii. Has the patient had prior therapy with a TKI? ❑Yes* ❑No
           - ***If YES***, please answer the following questions:
             - 1) Has the member experienced toxicity or intolerance to prior therapy with a TKI? ❑Yes ❑No
             - 2) Has the member experienced resistance to prior therapy with a TKI? ❑Yes ❑No
             - 3) Has the patient been tested for T315I mutation? ❑Yes* ❑No
               - ***If YES***, what was the test result? ❑Negative ❑Positive
   - ❑ Other diagnosis ***(please specify):*** _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Sprycel – FEP MD Fax Form Revised 1/1/2026

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Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Sprycel / Phyrago (dasatinib)

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Please select medication/strength and provide quantity:

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Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on Sprycel continuously for the last **6 months** excluding samples? ***Please select answer below:***
   - ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

   a. What is the patient's diagnosis?
      - ❑Gastrointestinal stromal tumor (GIST):
      - ❑Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML)
      - ❑Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)
      - ❑Other diagnosis ***(please specify):*** _____

   b. Has the patient had a complete or partial response to therapy or a lack of disease progression? ***Please select answer below:***
      - ❑Complete / partial response to therapy
      - ❑Lack of disease progression
      - ❑No response to therapy
      - ❑Patient has had disease progression

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